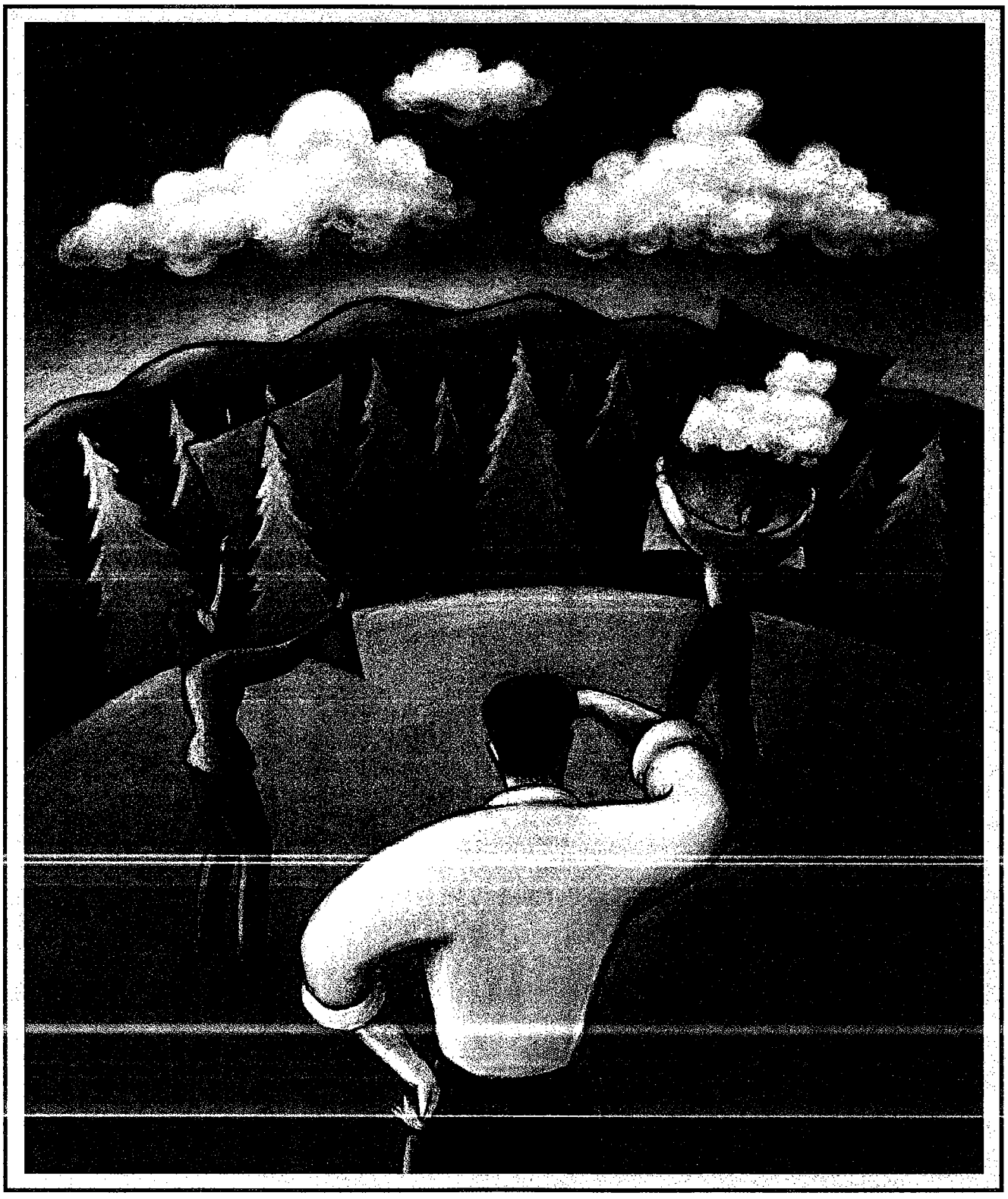


Leaders express plans to diversify services, find new

Redefining The Long Term Care Landscape

Marla Fern Gold

This spring, Health and Human Services Secretary Michael Leavitt announced plans to trim $10 billion from the federal Medicaid program by 2010. According to one source, Medicaid foots the bill for nearly 70 percent of all long term care patient stays, making the proposed cuts a vital issue for long term care providers. In fact, says a spokesperson for The Evangelical Lutheran Good Samaritan Society, "We lose money on every one of our [Medicaid] residents, about $15 per day."

On top of this fiscal news, the Centers for Medicare & Medicaid Services (CMS) is actively looking for opportunities to shift long term care services to home- and community-based care, meaning that skilled nursing facilities no longer would be the "center" of care, but rather the last care option in many cases.

As a result, long term care leaders are acutely focused on finding ways to remain financially stable in the face of dwindling government resources for reimbursement and on developing new market niches as they look for ways to meet consumer needs in the future.

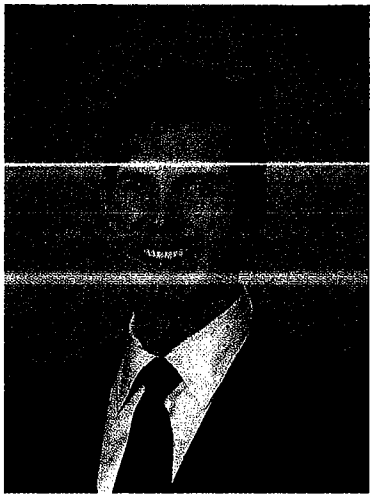
Checking With Top Providers

Recently, *Provider* spoke with top executives from skilled nursing and assisted living, congregate care housing, and services for people with mental retardation, both for-profit and not-for-profit, to capture the pulse of the profession and its future: Paul Diaz, president and chief executive officer (CEO) of Kindred Healthcare, which operates nearly 32,000 beds in 249 facilities; George Hager Jr., chairman and CEO of Genesis HealthCare Corp., operator of more than 23,500 beds in 12 states; Dan Holdhusen, former chief financial officer with The Evangelical Lutheran Good Samaritan Society, which operates more than 14,500 beds throughout the Midwest; Richard Matros, chairman and CEO of Sun Healthcare Group; Michael Leader, president and CEO of Country Meadows Retirement Communities, in Hershey, Pa.; Jeff Ferguson, president of operations management with Erickson Retirement Communities; Steven Chies, American Health Care Association (AHCA) chair and vice president of operations, long term care services, with

v revenue streams, and step up emphasis on quality.

Benedictine Health System; and Ron Geary, chair, president, and CEO of ResCare, a provider of services for people with disabilities that services 32,000 individuals in 32 states.

These leaders share a vision for the future of long term care: quality care and services paired with financial viability and a skilled workforce to meet the growing acuity and diversity of tomorrow's long term care consumer.



Paul Diaz

Dan Holdhusen

Ron Geary

Financing Crisis

Financial viability is on the minds of today's health care executives. A new analysis of the nation's Medicaid program by the accounting firm BDO Seidman reveals that states are underfunding nursing facility care by at least $4.5 billion annually. The report warns that this underfunding will "continue to increase every year because rate increases have not kept pace with nursing home cost inflation."

Add to that the proposed cuts, and providers are looking for other revenue streams to remain financially viable.

"We are at a crossroads," says Holdhusen, of Good Samaritan. "For many years, we've been relying on revenue from government sources, both federal and state, Medicaid and Medicare. We have reached the point of budget crisis now.

"The federal government is at a record-high deficit, and the consequence of that is the need to pare back," he adds. "This comes at a critical time for us with the aging of America. There are 10,000 individuals reaching age 65 each day, and that will continue to grow each year. By 2010, that first wave of retired individuals is going to hit us."

Good Samaritan's facilities, which rely on Medicaid reimbursement for about 60 percent of their residents, lose about $15 per day on each Medicaid resident.

In fact, with its religious mission of "providing shelter and supportive services to older persons and others in need," Holdhusen, currently Good Samaritan's vice president for public affairs, says the company operates in some markets "knowing it will never be a money maker. At the same time, it is important for us to continue the mission.

"Obviously, we need margin to meet our mission. But we do look at our job of 'mission before margin,'" he says. "We are trying to diversify into other revenue streams to provide more margin so we can continue the mission, but the mission is preeminent."

As a result, the company is focusing on other ways to increase revenue. "We have to make up the differential somewhere else," says Holdhusen. That's why the company, as well as others, is looking to diversify services to bolster profitable revenue streams.

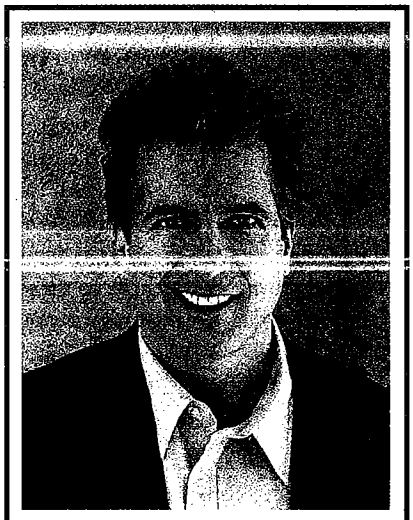
New Funding Streams

ResCare, which cares for adults with developmental disabilities in home and residential settings, finds itself in similar circumstances, says CEO Geary. "The bulk of our clients are Medicaid-eligible," he says. In addition to instituting measures to become more cost-efficient in operations, ResCare is moving toward more community-based care for the elderly to "diversify the funding stream." This strategy, says Geary, "allows us to start trying to reduce the high percentage of Medicaid we rely on."

But diversifying is not the whole answer, says Holdhusen. "Our intent is not to abandon those people who are Medicaid-qualified, but to be involved actively in discussions of Medicaid reform. There isn't one silver bullet, but a whole myriad of things, like asset transfer reform and tightening down on inefficiencies in the system. We try to run a very efficient system, but overall Medicaid is so massive, there is potential for lots of inefficiencies."

What is telling, says AHCA Chair Chies, are efforts on the state and federal levels to promote individual responsibility for long term care planning. "We're seeing a movement

around the country, and specifically in Washington, that government is not going to be able to provide supportive living arrangements, and people need to make their own plans." As evidence, he cites a public service announcement currently running on radio stations in Minnesota that urges residents to begin planning for their long term health care needs. "States around the country are telling people to set aside funds and resources for their own needs and their family's needs," he says.


Richard Matros

He continues, "With the right motives and the right incentives, consumer attitudes about paying for health care could change fairly quickly to put people in charge of their own health care, including long term care."

Holdhusen agrees. "We need to find ways in which we can get people accountable for their care," he stresses.

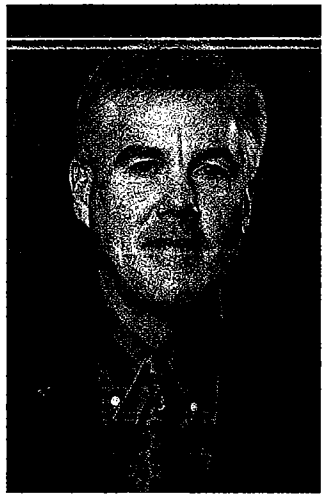
Diversifying Services

Sun Healthcare, headquartered in Irvine, Calif., has deepened its portfolio in the past few years to offset government shortfalls. The company, which restructured in 2003, owns home care and staffing businesses, a rehabilitation therapy company, and a radiology company, in addition to skilled nursing care. Currently, the company is expanding its home care and staffing businesses to meet new market opportunities.

As a result of its efforts, CEO Matros says that while the Medicaid inpatient portfolio is around 50 percent, on an aggregate basis Medicaid accounts for only 37 percent of total revenue. "Diversifying helps us to mitigate risk," he says.

"For companies to survive and thrive, they will have to diversify their portfolio, whether in ancillary businesses or assisted living and independent living, hospice, or into other complementary business lines that will synergize with their existing portfolio," says Matros. Another option, he adds, is for companies to "expand into business ventures that are less regulated and less government-dependent from a reimbursement perspective.

"I think having different service businesses that are relatively easy to acclimate to in terms of managing helps to diversify risks so you're not completely dependent on long term care," he adds.


George Hager Jr.

Adding Pharmacy, Congregate Care

Kindred has done just that since emerging from bankruptcy protection a few years back. The company, says CEO Diaz, has paid down almost $400 million of debt since its emergence from bankruptcy, and now boasts a portfolio that includes the fourth-largest institutional pharmacy in the country; a contract rehabilitation business; the largest operator of long term acute care hospitals; and, according to *Provider*'s latest survey of the top 50 chains, the third-largest nursing facility provider in the United States.

"We have benefited from diversification," says Diaz. "We certainly went through a chapter in the industry where the diversification strategy failed from a combination of people incurring too much debt and poor execution. We've done neither." He says the company's policy of fiscal conservancy and investment in the workforce is paying off.

For Good Samaritan, beefing up its congregate living components has helped to offset Medicaid inadequacies. "Social services, housekeeping, transportation, meals, that sort of thing, has helped create for us a revenue stream for the future that will make up for a loss on the Medicaid side," says Holdhusen.

Already, this approach is having an impact on services, he says. In 1990, 95 percent of Good Samaritan's business was in skilled nursing, he says. That figure is down to about 85 percent today.

"We're about a $700 million per year company, so that is a dramatic growth in assisted, independent, and congregate living and a significant expansion into community-based services."

"We don't see the day when skilled nursing will be eliminated, but we see that as a lesser part when compared to the emphasis we put on skilled nursing in the past," Holdhusen says.

A Different Approach

One company that isn't looking to integrate is Genesis, which is sticking to its core business of short-stay rehabilitation and long term care following an unsuccessful diversification attempt several years ago.

Says Hager, CEO, "In the old days, Genesis Health Ventures had a diversification strategy of trying to develop an integrated network of providers to

meet most of the needs of the elderly. Since [a recent restructuring], unlike our public peers, we're more focused on skilled nursing. We have not diversified into assisted living, hospice, home care, or any of the other adjacent businesses our peers have chosen to diversify into.

"I'm not saying that's a bad strategy, but we believe there is a significant opportunity in the core business. We do not see a whole lot of people focused on the core skilled nursing business."

As part of its "core" business, Genesis is acutely focused on the short-stay rehabilitation patient.

"Genesis HealthCare is principally a skilled nursing provider, but we actually serve two populations. We do serve a long-term population, but we also serve a subacute short-stay population."

While long-term patients want a more resident-centered approach to how care is delivered and a more homelike setting, the short-stay population is more focused on clinical skills.

"To the extent that the skilled nursing industry can offer a product and a service—including the amenities and the feel of what exists today in the rehabilitation setting—and can also track the clinical skill needed to provide the necessary care, I think there will be a growing demand for rehabilitation services in the skilled nursing environment," says Hager.

Steven Chies

Moving Into Assisted Living

For many companies, the first step toward diversification has been a foray into assisted living. For these providers, defining the care options and preventing excessive regulation are the real challenges. Says Chies, "Assisted living is in such a state of flux that there is no clear indication as to what assisted living will be doing as a sector of health care. The challenge of assisted living is that there is really no clear definition of what it is."

He continues, "At least on the skilled side, we have a much better definition of the services we're providing and of the expectations. With assisted living, we have everything from 'mom and pop' operations with five elderly persons living in a house that was designed for a large family, to extremely formalized organizations with protocols and aging-in-place and 24-hour care. And we have everything in between."

Michael Leader

Chies says that the current uncertainty about what assisted living provides creates confusion in the marketplace.

Leader, of Country Meadows, cautions that whatever assisted living grows into, providers must ensure top-quality services to prevent the need for federal regulations. He says, "If members of our profession are communicating well with congressional staff that state governments have regulation well in hand and are capable and competent to regulate the industry, we stand a chance of avoiding federal regulation." He emphasizes the importance of working with groups such as AARP to "recognize that having several different models of assisted living regulation is a benefit rather than a liability."

For assisted living providers to continue to grow in the marketplace, Leader says they must "be able to detect the changing expectations of seniors and provide a growing list of amenities that will be expected in assisted living, such as homelike and attractive decor, more choices in dining, a community life initiative that's more sophisticated than Bingo and the 'morning stretch,' and good staff."

Point Of Service

CMS is undertaking several initiatives to try to shift health care options from long term care facilities into home- and community-based services (HCBS) in an effort to meet consumer expectations while alleviating growing health care costs. While in the past, the nursing facility stood at the center of long term care services, new models posit home as the center of care, with services coming to the patient, rather than the patient coming to the services.

While the use of HCBS has a place, this model will create unreasonable expectations, says Chies. "I'm not sure that's the right model," he says. "If it is the right model, to bring everything to the person, then why don't we do brain surgery on someone's kitchen table? At some point in time, we need to say that we can't provide this level of services for this person in a competitive marketplace.

"If you say to people, 'We're going to leave everybody in their home

across this country,' we've got places where the closest town is 100 miles away, and the closest neighbor may be 50 miles away," he adds. "How is it cost-effective to have services brought to that person?"

In addition, he says, the workforce to provide such care is not going to be available.

Leader sees problems with this initiative as well. "Regulators and state governments have the perception that home- and community-based care is less expensive than facility-based care, and that people prefer that. I think they are very short-sighted."

He continues, "There will always be a place for skilled nursing care, and if they are not careful, policy makers will seriously harm the skilled nursing component of long term care to the point where it will not be available at the level needed when the senior population really jumps."

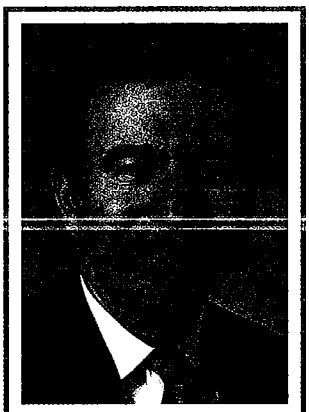
Taking Care To The Home

For rural providers like Good Samaritan, this model poses myriad challenges as well. "This industry has moved more toward the home- and community-based care side," Holdhusen says. "Our objective is focused on how we can keep people in their 'independent place' for as long as possible."

However, he says that in some rural areas, a continuum of care is just not affordable.

In an attempt to mitigate this problem, the company is participating in a pilot project in rural North Dakota called the North Dakota Community of Care Project, which relies on volunteers to deliver meals, drive elders to appointments, shop for groceries, and provide other nonmedical services. Good Samaritan assists in coordinating care needs with help from local social services organizations, churches, and individuals.

"This gets us away from the entitlement mentality," says Holdhusen, while finding ways to bring services to people who otherwise would not be able to remain in their homes. He cautions, however, that as individuals require medical care and services, or more activities of daily living care, such a program will not be enough.



Jeff Ferguson

ResCare is taking advantage of Medicaid waivers that allow its caregivers to provide five to 10 hours of care weekly in people's homes, augmenting the informal care provided by family members. Says Geary, "States are trying to take their limited dollars and serve more people, and this is one way they are doing it. It's becoming a good-sized piece of our business." To remain cost-effective, ResCare has 110 core offices in suburban areas throughout the country, so clients are usually less than two hours from a core office. "We learned many years ago that we need to cluster our operations," he says.

Congregate Care Environments

A more feasible option for most long term care operators, says Chies, is to create more congregate care environments free from the current institutional bias to provide cost-effective, quality care in the most independent environment. "Essentially, what will happen is that we'll need to bring people into central locations and we will need to figure out how to provide services in a much more congregate setting. There is no question in my mind that we are going to have to provide care for people in congregate settings—whether it's in a nursing home, assisted living facility, catered living, or apartments. But it really doesn't matter what the setting will be, we're going to have to be much more clear on expectations."

One model that's successfully combined all services into one is the congregate care retirement community (CCRC). At Erickson Retirement Communities, headquartered in Catonsville, Md., services include independent living, assisted living, skilled nursing, rehabilitation, home care, mental health programming, and physician services. Each of the company's dozen campuses also houses banks, restaurants, grocery stores, a health club, chapel, swimming pool, dentists, and other amenities.

However, this arrangement isn't for everyone, because this type of living comes with a hefty price tag: Erickson residents must pay a significant deposit, plus monthly fees for services and housing. Ferguson says the model is aimed at the middle-income retiree, who would move in prior to the need for long term care services. While the move-in age is 62, in practice most residents move in when they are in their mid-70s or later, he says.

While the CCRC currently is very distinct from other long term care options—it's a housing lifestyle option for healthy seniors as opposed to a health care service for individuals who are sick and disabled—its genesis can teach lessons to today's long term care providers, according to Ferguson.

"Erickson started with independent

living apartments, and as residents' needs grew, the company began offering assisted living, then skilled nursing," says Ferguson. Similarly, "Most companies that went into long term care chose a segment and said, 'We'll segment in this and contract out the other services we do.' Today, I see across the industry more of a movement toward the integrated model, and that integrated model begins to pick up other segments that providers feel most appropriately augment their piece of the business."

'The reality is that we cannot just abandon the facilities we have to build more friendly models.'

Capital Needs

For the CEOs, the need for new capital investment trumps almost any other issue, due to the aging of buildings and consumer desires for smaller, more homelike settings.

"I think capital is more critical at this point than just about everything else because the infrastructure is deteriorating," says Hager. The average Genesis facility is 27 years old. Other companies possess buildings that are 40 or more years old.

Adds Diaz, "We have a significant obsolescence problem in skilled nursing. We also have a lot of places where the facility is full, but in three- and four-bed rooms, and that obviously is not ideal."

Diaz says that, while relations between providers and federal and state governments have improved markedly in recent years, "The issue of the physical plants and obsolescence: I don't think that people in Washington really have embraced that yet as a real issue."

Further, he says, legislators do not understand that "if you don't have stable reimbursement, you cannot have capital formation. For people to be willing to invest capital to renovate or build nursing facilities, they expect a reasonable rate of return, and if the reimbursement is not there to support a reasonable rate of return, that encumbers the ability of operators and investors to address the obsolescence issue." Still, to meet consumer demands, Kindred and Genesis have both embarked on aggressive modernization programs.

How Companies Cope

Kindred is finishing up a $21 million investment to replace all of its crank beds with electric beds and state-of-the-art mattresses. In addition, the company has installed sprinklers in each of its facilities and this summer will have air conditioning in all buildings. But as an industry, says Diaz, "We still have too many leaky roofs" and not enough capital to repair them all.

Good Samaritan, the nation's largest not-for-profit long term care company, has been more conservative in its new construction spending, but still looks for ways to improve its aging buildings. "The reality is that we cannot just abandon the facilities we have to build more friendly models," says Holdhusen. Instead, the company has tried to retrofit and redesign existing buildings to better reflect consumer desires and needs.

"It's a real challenge when we're dealing with 30- to 40-year-old buildings," he says, but "in our industry, there is not a whole lot of help to refinance infrastructure needs."

The Challenges Of Technology

CEOs point to technology as a partial solution to staffing challenges. "The use of technology will be a great way to expand productivity. Critics say we are in a high-touch business, but there are ways we can use technology to improve productivity," says American Health Care Association Chair Steven Chies. "Technology is clearly a key strategy."

Chies cites the use of radio frequency tags to track residents' health status as one example of a technology that could free up nursing time while improving care.

Adds Michael Leader, president and CEO of Country Meadows Retirement Communities, "We can make modest impacts on quality of life and efficiencies with the use of technology."

He says, for instance, that many providers use software for resident assessment protocols and development of a service plan.

"That's a good thing, because you can have flow through from the assessment to the service plan to the care assignment."

In addition, Leader points to computer-based education, which makes it possible for people who work on different shifts to receive orientation and training at their convenience. Wireless nurse call systems improve resident safety because people can call for assistance from virtually anywhere on the campus or facility.

Unfortunately, the use of technology has not yet caught up with its promise due to a lack of resources, say executives. "From an information technology standpoint, this industry has not been adequately supported," says George Hager Jr., chairman and CEO of Genesis HealthCare Corp.

"Our industry is fragmented, and the amount of capital our industry invests in information technology does not create opportunities for software to be developed."

Adds Sun Healthcare Group Chairman and CEO Richard Matros, technology "would help us to be more efficient and be able to present data in a usable way.

"We still do not have a top-notch clinical and financial model in our homes. We still have fragmented systems that you have to create interfaces for. There's a lot that needs to be done, but who has the capital to invest in it?"

The lack of capital to invest in the infrastructure will eventually lead to an access crisis, says Hager, a problem policy makers and the American public have yet to understand. "There has been a 10 percent decrease in the number of beds every year for the past few years," says Matros. "We've got physical plants that are aging, and the acuity of our patients is changing. How are we going to be able to accommodate patients who come to us in the future?" he asks.

Compounding the access issue is the fact that while most care currently is provided by family members on an informal basis, demographics and distance will dramatically reduce this trend in the future. Says Chies, "What people don't realize is that about 90 percent of care in this country is provided on an informal basis. That will always be the case to some extent, but it will decrease because we won't have enough people to provide this care. Once a spouse is gone, who will provide care?" he asks.

Highlighting Quality Improvements

A bright spot several executives point to is long term care's dedication and leadership in promoting continuous quality improvement efforts, as exemplified by AHCA's Quality First program and the public-private partnerships between providers and CMS.

"One area in which I think we've made a lot of progress is in support from our congressional representatives, and that has much to do with the initiative of Quality First and efforts with CMS to make data public, as well as the subsequent documented improvement in quality in the last couple of years," says Matros. "We're the only sector of health care that really stepped up to this, and I think that has everyone's attention."

Adds Diaz, "I think what we all have to be proud of is that statistics show that the quality of the care we are delivering is improving. The Quality First pledge, and people embracing quality as a 'must have,' not a 'nice-to-have,' is making for a better industry."

The next step, he says, is "for us to tell that story better. We still fight a public perception challenge."

Hager agrees. "When we look at the current battle the industry has been waging to try to preserve current levels of funding, the whole platform has been around quality. It's very difficult to argue for improved funding if we don't commit to improving the quality we provide."

Quality, Respect, Compensation

As a result of quality efforts, Matros says, "I think there is a level of respect that was not there before the last two to three years, responding to our willingness to take some risks and put our agenda out there as a quality agenda. Before, when dealing with potential reimbursement cuts, we had nothing to hang our hats on. Now, we have data to back us up, so when we say that if our rates are cut it will have an impact on quality, it's hard to deny."

Genesis applies the same approach to its in-house incentives, tying compensation to meeting clinical objectives. "We emphasize clinical performance and actually tie that to compensation. It demonstrates the fact that we are committed to developing the best

clinical outcomes as an organization," says Hager.

While not part of the Quality First effort, ResCare is focused on quality improvement through its "Best in Class" program, which includes monthly surprise surveys performed by employees. "It is a peer review program whereby we might have somebody who operates a home in the east side of the city visit a home on the west side and perform an independent surprise survey," says Geary. In addition, the company has a self-directed compliance program. "If we lose our quality, we lose our business," says Geary. "We are focused on having and maintaining cutting-edge quality."

Staffing For The Future

Key to every company's quality efforts is its workforce, especially skilled staff. Recruiting, retaining, and compensating skilled staff is an issue on the minds of all executives.

"Recruitment and retention is always an ongoing challenge for us," says Diaz.

Chies sees the problem in terms of numbers. "Our basic challenge as a society is that we won't have enough bodies to provide care, so we are going to have to look at more innovative ways to structure our programs," he says.

One way is with the use of the "universal worker" model, says Chies. "We are not going to have the numbers of people to be specialists. If you look at the more residential model, it makes sense to have one person in the living unit, evaluating the residents, changing light bulbs, etc., rather than having the highly segmented workforce that we have had in the past."

To do that, he says, jobs will need to be restructured so people are more adaptive in changing jobs as needs change.

Diaz sees things a little differently. "We need to be competitive in wage rates, we need benefits that are flexible and address the diversity of our workforce, we need flexible schedules, and we need to offer health plans that have different levels of insurance coverage, so that everyone can have access to health care, even if it is at the catastrophic health care level," he says.

Geary concurs. "We have tried to incorporate into our lobbying efforts the fact that there is a real shortage of people who can afford to work, with the people we serve, at the wages we can afford. This will continue to be a tough issue as Medicaid rates remain tight and we cannot pay our people what we want to pay."

Staffing Incentives

In the meantime, providers are focusing efforts on career ladders, mentoring, incentives, and other programs to recruit and retain skilled staff.

Just this spring, Kindred unveiled a new employee wellness program aimed at encouraging staff to give up bad habits like smoking and invest in positive lifestyles that include exercise and healthy eating.

"We're offering a health screening assessment with professional counselors, who in turn will try to encourage employees to make changes in their lives," Diaz says. The program plans include offering health insurance discounts to employees participating in the program. "This says to our employees that we care about them," says Diaz.

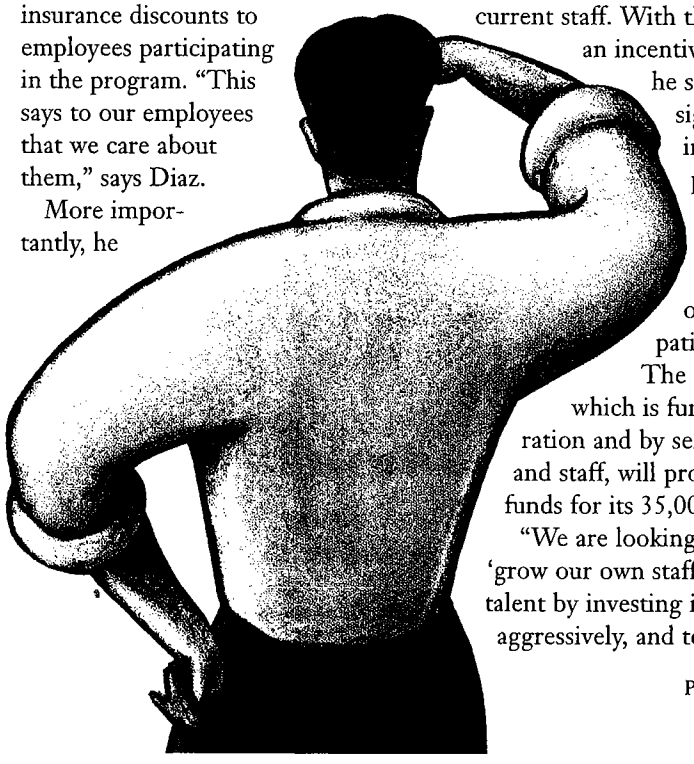
More importantly, he adds, the company is promoting a culture that honors staff and rewards them for clinical competence and caregiving.

At Country Meadows, career ladders for personal care assistants permit staff to rise to management-level positions without a nursing degree. Says Leader, "We're developing career ladders for people to go from entry level to a higher management level, and freeing nurses from oversight responsibility."

Genesis has invested heavily in workforce staffing and retention efforts, including tuition assistance for skilled nurse assistants and licensed practical nurses to achieve a higher rung on the career ladder, employee service and seniority recognition initiatives, active mentoring programs, and a brand-new foundation that funnels money to employees in financial crisis.

Of these efforts, Hager says, "We have focused aggressively on growing our own professional skills in a variety of ways. We have completely revamped our administrator/director of nursing leadership program with a hope that we can recruit and retain more effectively the people we need.

"We have also aggressively put in place tuition assistance programs to effectively fund the education of our current staff. With that funding comes an incentive to stay with us," he says. "We allocate significant capital into that program. I personally don't think we could spend enough to meet the demands of our current patient population."



The new foundation, which is funded by the corporation and by senior management and staff, will provide emergency funds for its 35,000 employees.

"We are looking to be able to 'grow our own staff,' develop our own talent by investing in our people more aggressively, and to be more employ-

ee-friendly by recognizing the tenure and needs of our employees.

"It's not an easy problem to solve."

Elevating The Profession

One thing Ferguson thinks will help is the elevation of long term care into a more prestigious career. "I think this industry, whether you want to call it senior living services or senior care or long term care, is still very much in its adolescent stages when it comes to maturation of organizations and of management skills and talents. I think over the next 10 years, especially with the impending arrival of the baby boomers in the next 20 to 25 years, we will see more legitimacy come about for studying long term care management, and we'll see more people making a conscious decision to enter the business."

One way to promote this change, says Leader, is to push for changes in education.

"I think the enlightened providers are doing everything they can to transform what we do into a profession, just as acute care has made its various specialties into professions," he says.

"I think one thing that would convey to people that working at a facility is more than just a job would be to have more colleges offering a degree that would recognize personal care, assisted living, direct care staff, certified nurse assistants, as a profession, both as associate degrees and bachelor's degrees," he says.

"Until that happens," says Leader, "some people will not be convinced that this is a profession worthy of a career, rather than just an entry-level job."

In the end, he says, "Long term care...will be viewed as more of a legitimate profession. I think more academic studies around senior living will help to make it so people come to view it as a viable profession."

"Going forward, we have to follow through and continue to focus on the quality of our services and the customer experience, and we need to do a better job from a public relations standpoint of helping people understand the value proposition that we bring," says Diaz.

"We need to help people understand that we are taking care of a sicker, much more medically complex population than we have ever had, and that requires stable, predictable reimbursement upon which providers can continue to look" to improve staff competencies. "I think that's an opportunity for providers, and it's an opportunity for our residents." ■

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